THE RHODE ISLAND MEDICAL JOURNAL

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ORIGINAL ARTICLES

IDEALS AND ETHICS*

PRESIDENT'S ADDRESS

BY ALBERT H. MILLER, M.D.

PROVIDENCE, R. I.

We celebrate, at this meeting, the seventy-sixth anniversary of the founding of the Providence Medical Association. What vision of the future was in the minds of the founders, we cannot know. We doubt if it was more brilliant than the present success of the association. We learn from the charter the objects of the association:—"the advancement of sound medical science and the promotion of the character, interests and honor of the medical fraternity." For the first of these objects, "the advancement of sound medical science," we hold each year, nine monthly meetings at which medical cases and specimens are presented and scientific papers are read and discussed. Through its membership, the association is intimately connected with the staffs of twelve first grade hospitals. The activities of these institutions and of a medical fraternity singularly free from dissention and discord, produce a wealth of scientific material of which this association is the principal outlet. In addition to these advantages, the association is intimately connected with the faculty of a great university and is within easy distance of many of the world's greatest medical institutions.

In the utilization of this great mass of scientific material, the only handicap under which the association labors is lack of time. We have been unable, through lack of time, to pay to the discussion of papers the attention which they merited and which the members of the association would have enjoyed. Through lack of time, we have sadly neglected the presentation of cases and of specimens, which should be valuable and interesting features of all our sessions.

*Read before the Providence Medical Association, at the Annual Meeting, January 4, 1926.

By starting our meetings promptly and by reducing the time spent on routine business to the minimum, we have succeeded during the past year in bringing out about twice the number of papers usually presented, without apparent hardship to the members of the association. We are trying, this evening, the innovation of a scientific paper on the program of the annual meeting. Having found that we can gain an appreciable amount of time in the ways indicated, the next step for consideration will be the advisability of scheduling meetings at a somewhat earlier hour. We could also readily arrange for one extra meeting a year. No meetings are at present held in July, August and September. The only reasons for not meeting in September are lack of precedent and authority.

In carrying out the second of the objects of the association, "the promotion of the character, interests and honor of the medical fraternity," we have the great advantage of an intimate connection with the American Medical Association. The Providence Medical Association alone decides what members of the community are eligible for membership in the American Medical Association. Through our representation in the House of Delegates of the Rhode Island Medical Society, which is in turn represented in the House of Delegates of the American Medical Association, the Providence Medical Association takes its part in controlling the policy of this greatest of medical organizations. The American Medical Association is constantly striving to improve the character, interests and honor of the medical fraternity. You are familiar with the results of its campaign for clean medical advertising. Although this campaign is carried out unobtrusively, the results are such that objectional medical advertisements are no longer to be found in approved medical journals nor in the better newspapers and magazines. In 1900, the American Medical Association began the publication of statistics in regard to the medical schools of the country. Medical education was then in deplorable condition. Most of the colleges were poorly equipped as to laboratories, clinical advantages and instructors. Many were conducted

solely for private gain. Some were mere diploma factories. As the result of the publication of statistics in THE JOURNAL year after year, and of the work of the Council on Medical Education, established by the American Medical Association in 1904, the medical colleges of the country are now in satisfactory condition. Many are connected with great universities and have their own teaching hospitals and dispensaries. Seventy-one of the eighty medical schools of the country fulfill the rigid requirements set by the Council on Medical Education for Class A medical schools. This striking result has been achieved by strictly ethical means: — through publication of data in THE JOURNAL, by enlisting the co-operation of medical faculties and state licensing boards, and without dissemination of propaganda through the daily papers. In 1914, the American Medical Association started a similar campaign for the improvement of hospitals. In 1919, it joined with other organizations interested in hospital welfare to form the American Conference on Hospital Service. The improved conditions in our hospitals which have resulted from these activities are everywhere evident. I have dwelt at some length upon this work of our national organization for the following reason: Recently there appeared in our local papers some misleading propaganda to the effect that the standardization of hospitals is due solely to the work of one of the minor organizations belonging to the American Conference on Hospital Service. Such unethical methods give us little concern and are mentioned only to accentuate the highly ethical stand taken by the American Medical Association in matters for the common good.

Maintenance of a high standard of medical ethics is a principal function of the American Medical Association and of its constituent societies. A code of ethics is to the medical profession what a code of morals is to youth. While it is formulated distinctly for the benefit of the patient, its final advantage is for the medical profession. The Principles of Ethics of the American Medical Association governs the conduct of the members of the Providence Medical Association in their relations to each other and with their patients. The past generation of members of this association—their revered names are still fresh in our memory—maintained a high standard of medical ethics and left us a heritage of the greatest value. We have in Providence a united medical fraternity, unusually free from jealousy and functioning with a minimum of friction. Relations with patients are on as happy a basis as those between our members. Malpractice suits against members of this association are practically unheard of. Many widespread violations of the principles of medical ethics have never gained a foothold in this district. The secret division of fees is not a feature of our professional relations and is never practiced by the reputable physicians of the community. Professional fees are based on the value of the service rendered and not on the basis of percentage of the income or wealth of the patient. In the selection of assistants, our surgeons universally choose the most highly trained available without regard to the fact that they could increase their immediate income by employing the untrained and inefficient for this important work. As one result, we do not have the nurse or lay anesthetist problem which is becoming more and more difficult in many communities. In the conduct of our hospitals, the authorities strive for the welfare of the patients but do not overlook the interests of the medical and surgical staffs. We are singularly free from abuse of hospital privileges by patients who are not entitled to free service. Our Workman's Compensation Act has reasonable regard for the interests of the medical profession and does not foster the disgraceful conditions under which compensation work is done in neighboring states.

Our plain duty is to preserve and to pass on undiminished the high ethical standard which we have inherited. Each member of this association should be conversant with the Principles of Medical Ethics as promulgated by the national organization and should make these principles his guide in his professional relations. Consultations on difficult cases are resorted to less frequently than was the case formerly. Such consultations resulted in benefit to both patient and consultants and should be more in favor than they are at present. An unfortunate feature of increased medical specialization is the treatment of patients by specialists without advice and consultation from a family physician. The inevitable extension of specialization to cope with the swiftly gaining flood of medical knowledge has changed the con-

ditions but not the ethical principles underlying medical practice. Neglect of the privilege of consultation, aided by group practice, contract practice and free or partly paid clinics, is rapidly pushing aside the general practitioner of medicine. This lack of co-operation often results in the patients turning to chiropractors, osteopaths or to medical services in other cities. The present remedy for this condition lies not in a revision of our code of ethics but in study and observance of our present code.

The changed status of homeopathy presents an ethical problem. There are two homeopathic medical schools in the country, one listed by the American Medical Association in Class A, and one in Class B. There are six homeopathic hospitals maintaining such a high standard that they are included in the list of hospitals approved for interneships by the Council on Medical Education and Hospitals. Practice in these hospitals differs in no respect from that in other hospitals. Members of this association are on the staff of the Rhode Island Homeopathic Hospital and consult with graduates of homeopathic schools without prejudice. It can no longer be said that graduates of homeopathic colleges are practicing or supporting an exclusive system of medicine. It would be for the common interest to persuade these men to give up their special society and to invite them to become members of this association.

If time permitted, I would like to dwell upon the services of this association to the community in providing free medical treatment to the poor and upon the cheerful and gratuitous medical treatment of members of the medical profession and their families, an instance of organized unselfish service unique in a commercialized age. This service is performed with no idea of immediate or ultimate gain but in accordance with medical tradition dating from the time of Galen and Hippocrates.

With a feeling of deep regret I approach the end of my term as President of this distinguished association. The spirit of co-operation among members, committees and officers has made my year's duty a pleasure. I am greatly indebted to the officers and committees of the association for counsel and aid. The members of the standing committee have attended their meetings promptly and regularly. The collation committee has performed its duties with evident success. The Treasurer has guarded our finances with the careful attention evident in his report. The Secretary has presented accurate, carefully phrased reports of the transactions of the association and of the standing committee. I suspect that many midnight hours were spent in their preparation. For his advice and assistance, frequently sought and cheerfully granted, I am especially grateful. To those who have contributed so largely to the success of the year's work by reading and discussing papers, I extend my personal gratitude and that of the association. Many of the younger members of the society have read papers during the past year. Their work has been valuable, interesting and well received. To those whom I have neglected in the preparation of the programs, I offer an apology. My neglect has not been intentional but inevitable to the selection of a comparatively small number of papers from an abundant mass of valuable material. For my successor in office I ask the same co-operation which has made my year's work a pleasure and its termination a cause for regret.

THE TREATMENT OF AURICULAR FIBRILLATION*

SAMUEL A. LEVINE, M.D.
BOSTON, MASS.

Auricular fibrillation is a disturbance in the mechanism of the heart that occurs in a great variety of conditions. This disorder follows the institution of a circus motion in the cardiac impulse which instead of progressing normally from the pace maker at the sino-auricular node and traveling peripherally in the usual manner to activate both auricles rhythmically, pursues a continuous and irregular course around the mouths of the superior and inferior vena cava. The circuit is completed in about 1/400 of a minute and because of the extremely rapid rate and the difficulty which the impulse finds in passing from fiber to fiber, it moves now to one side and now to another always seeking tissue that has already recovered from the refractory state which followed

*Read before the Annual Meeting of the Rhode Island Medical Society, June 4, 1925.

From the Medical Clinic of the Peter Bent Brigham Hospital, Boston.

the previous contraction. As a result, neighboring bits of auricular tissue may be on the one hand trying to contract and on the other hand motionless. Consequently the body of the auricle does not actually contract but rather remains more or less distended in diastole with fibrillary twitching going on here and there. The impulses in this condition number around 400 to the minute and all try to get down to the ventricle through the conduction apparatus, i. e., the a-v node of Tawara and the Bundle of His. The conduction tissue is able to transmit but a portion of these and the result is an irregular rapid contraction of the ventricle.

This condition in the past has had various names—perpetual arrhythmia, absolute or total irregularity of the heart and delirium cordis. It occurs most commonly associated with rheumatic mitral stenosis developing many years after the original rheumatic injury to the heart. Auricular fibrillation is also a very frequent accompaniment of the condition called chronic myocarditis in middle aged or elderly people in whom there is no important disease of the valves but rather some functional or structural damage to the musculature of the heart. The above two conditions account for most instances of the permanent form of auricular fibrillation, although the transient form is not altogether infrequent even with mitral stenosis and chronic myocarditis.

The third condition in which auricular fibrillation occurs with frequency is hyperthyroidism, for here it is not at all unusual; as a rule it is the paroxysmal type. In some cases of hyperthyroidism paroxysmal auricular fibrillation may be the the only striking finding that the patient manifests. The close association of such paroxysms and an underlying thyroid disturbance one must constantly keep in mind. Occasionally auricular fibrillation interrupts the course of acute infections, particularly rheumatic fever and pneumonia, and though generally under such circumstances it is transient it may remain permanent. At times it produces an acute heart upset during the convalescence following any surgical operation. I have seen this happen several times. It also is not a rare occurrence during the course of digitalis therapy in an otherwise regular heart. There remains a small group of patients in whom transient auricular fibrillation develops where it is difficult to picture its relationship to the complaints, such as gall bladder disease, urticaria and angio-neurotic edema, etc. Finally, I have seen several individuals with transient auricular fibrillation and one with the permanent form who after the most thorough examination showed no evidence of any disease whatever; the heart except for the arrhythmia seemed entirely normal. One can readily see that after the recognition of auricular fibrillation in any given patient the treatment will depend somewhat on the underlying condition.

Before taking up on the important question of treatment let us first consider the means we have of diagnosis. At the outset it is well to remember that auricular fibrillation, in the great majority of instances, can be recognized at the bedside using only those means that the physician always carries with him. A convenient rule is one I heard Sir Thomas Lewis make years ago, i. e., given a decompensated cardiac with a heart rate as counted at the apex of over a hundred and a radial pulse rate that is appreciably less, (a pulse deficit of ten or more beats) if the rhythm seems grossly irregular and the pulse is irregular in both time and force the condition is auricular fibrillation nine times out of ten. There are occasional exceptions when an apparently total arrhythmia results from auricular flutter, numerous extra systoles and other disturbances, but they are not common. If in addition there can be found an underlying disease that frequently is associated with it, like mitral stenosis or hyperthyroidism, the diagnosis is even more certain. Proof of its presence may be obtained by the use of graphic methods, for in polygraphic tracings the auricular wave disappears as the auricles are no longer contracting and in the electrocardiograms the changes are quite pathognomonic. These examinations although confirmatory are not generally necessary.

Apart from the treatment of the underlying and more general condition which is beyond the scope of this discussion, the treatment of auricular fibrillation is a matter of the intelligent use of digitalis. There is no other condition that so dramatically responds to the proper administration of digitalis, for in a measure it may be regarded as specific as mercury and salvarsan are for syphilis. In hyperthyroidism digitalis may prove helpful; but curing the patient of the thyroid disease can make it unnecessary for one to use digitalis there-

after as the fibrillation is apt to disappear. After all the other provisions are made for the care of the patient if auricular fibrillation exists it is then necessary to administer that dose of digitalis which will slow the ventricular rate to about normal. Untreated, the heart rate is apt to be rapid and many beats are ineffective in sending any blood to the capillaries where it is needed. Treatment produces longer diastolic pauses as the ventricular rate slows, all beats reach the periphery and the pulse deficit disappears. To obtain this result about two grams or 30 grains of powdered leaves or 20 c.c. of the tincture of digitalis is necessary for the average patient, (i. e., 30 milligrams per kilo weight).* This dose can be given quickly or slowly depending on the urgency of the situation, although when more than a few days are spent in the procedure a slightly greater amount may be necessary as about two grains of digitalis is being eliminated daily.

In the ordinary case where no digitalis has previously been given the patient should get not more than half the complete digitalizing dose during the first twenty-four hours. This would mean 1.0 gram of powdered leaves or 10 pills each containing 0.1 gram. They may be given two at a time and repeated during the day. It may be just as well to give only seven or eight such pills that day. The decision will depend on how sick the patient is, how certain you are that he has had no digitalis previously and how well he is going to be observed. The second day one should give about one-quarter of the full dose or about 5 pills of 0.1 gram each in divided doses. Thereafter the dose can be 0.1 gram three times a day until the desired effect is produced, when the patient is then placed on the maintenance dose of about 0.1 gram daily. The purpose of the maintenance dose is to conserve the improvement obtained by the digitalization from day to day, for inasmuch as the body would lose the effect of about 0.1 gram daily it must be replenished. If, however, the patient has been taking digitalis previously it would be unwise to give such large doses and more satistory to dispense 0.1 gram three times daily.

In general it may be said that digitalis is given until the therapeutic effect is produced. This result is easily gauged in patients with auricular fibrillation. The physician must follow the heart rate as counted at the apex. It will be found that the apex rate will gradually slow and the pulse deficit will simultaneously either disappear entirely or diminish. It is not sufficient to count the pulse rate, for this might be normal to begin with at a time when the heart rate is actually very rapid and the pulse rate may increase, let us say, from 60 to 80 as the ventricular rate is falling from 120 to 90. Other signs of improvement of the circulation will be observed such as an increase in urine output, a loss of weight, a diminution in the amount of oedema, a decrease in the degree of dyspnoea and a general improvement of the patient's condition. When such evidence is obtained before the calculated dose has been administered the drug should be discontinued and the daily maintenance pill of 0.1 gram be given. Patients vary somewhat in the amount of digitalis needed to produce an effect and so some will need less and others will need considerably more than the average amount.

Although it is extremely important to give sufficient digitalis to obtain proper results, it is also imperative that we should not give too much. We must therefore watch for toxic manifestations of the drug. These generally occur after the desired slowing of the heart rate is obtained and in that way may be avoided by omitting the drug when the rate has reached about 70. At times despite the usual care the final few pills prove to have been unnecessary and the therapeutic dose is exceeded. The indications of intoxication are of two types, subjective and objective. On the one hand the patients may complain of a stubborn nausea with or without vomiting. With this there is apt to be a general feeling of meanness and sickness. Rarely there is diarrhoea and visual and mental symptoms such as yellow lights before the eyes and even psychosis. On the other hand, evidence of toxic action is obtained by auscultation. The most common observation is digitalis coupling of beats. This is easily detected in hearts with previously regular rhythm, for then a regular pairing of beats is heard, a quick beat and compensa-

*It is well to remember in this connection that a minim is not a drop, so that in giving 1 c. c. or 15 minims of a tincture one cannot order 15 drops. The number of drops per c. c. has varied from 30 to 60 (and not 15 as one might have expected) in a series of tinctures that I once examined and the variations depended on the size of the dropper, the angle at which the dropper was held and the rate of flow of the drops. It is therefore impracticable to give drops and much more satisfactory to use pills of the powdered leaf.

tory pause occurring in regular sequence. In cases of auricular fibrillation it may be difficult to recognize this because the original irregularity already has some quick beats and pauses as characteristic of it. When digitalis coupling develops, however, it may be evident that whenever there is a quick beat a pause follows and that pauses do not come after a previous beat of normal length but always after a short beat. With experience one may diagnose this phenomenon from the sense of coupling that is elicited.

A further indication of intoxication is the development of heart block. In patients with auricular fibrillation this manifests itself in a change to a perfectly regular ventricular rate. When patients who have had the perpetual arrhythmia show a regular rhythm during digitalis therapy the drug should be omitted because it often indicates that complete heart block exists and that auricular fibrillation has not ceased. When this happens the regular ventricular rate is generally over 50 and may be over 100 although complete heart block is present. In other words regularization of the heart in auricular fibrillation does not necessarily mean that the normal rhythm has been established. Whether the fibrillation continued or ceased under such circumstances it would be wise to omit the drug and after several days if auricular fibrillation had not ceased the irregularity will reappear. If digitalis is continued when complete block has developed the poisoning may prove fatal. A final indication for discontinuing the drug is if unusual slowing occurs. The ventricular rate may drop below 50 and although no harm need result the optimum heart rate for a patient in bed is around 60. The above criteria are sufficient for all practical purposes to administer digitalis therapy properly in the ordinary cases of auricular fibrillation.

There are times when greater speed is needed in digitalization although this is rare. Under such circumstances a dose of 0.5 mg. of strophanthin may be given intravenously. This should not be carried out if the patient has had digitalis in the previous week, for there is danger of an immediate fatality. Realizing that a therapeutic effect on the heart may be obtained within 12 to 18 hours following oral administration it becomes rarely necessary to use any other method. At times vomiting interferes with digitalis therapy and this might require some method of administration other than the oral. It must not be forgotten that nausea and vomiting is as commonly the result of insufficient digitalis as it is of an overdose. It may, however, prevent the retention of the pills that are given by mouth. One can then give digitalis by rectum using an infusion or the tincture well diluted in water in much the same dosage as when used orally. Or one can use sterile ampules of digitalis intramusculary. The latter method is particularly applicable in surgical patients especially during the stage of anaesthesia. For a quick effect 0.5 to 1.0 gram of digitalis may be given at one time if the patient previously had not had any of the drug, and somewhat less if he had. Similar rapid digitalization using the intramuscular or the intravenous method is the procedure of choice in the rare instances where a grave condition exists. I once saw a patient suffering from pneumonia suddenly develop auricular fibrillation and quickly become moribund. A half hour after the intravenous injection of 0.5 mg. of strophanthin the apex rate fell from over 200 to about 100, the patient was revived and recovered.

The treatment for the transient form of auricular fibrillation has a slightly different aspect. If the attacks are rare they may call for treatment along the above lines for each specific attack. If they come frequently it might be possible to prevent their recurrence by giving constant daily doses of quinidine sulphate 0.2 to 0.3 gram two to three times a day. This is not always successful and when quinidine fails it is desirable to digitalize the patient as outlined above and to keep him so constantly. The difference between quinidine and digitalis in this respect is that the former tends to prevent the recurrence of auricular fibrillation and the latter prepares the heart so that when the fibrillation returns the ventricular rate does not accelerate. I have seen patients with transient auricular fibrillation complain of considerable distress and show a rapid, irregular heart during attacks when taking no digitalis and later when digitalized go through a paroxysm of fibrillation and be absolutely unaware of it because the heart rate though irregular during that spell would be quite slow. There is considerable difference of opinion whether quinidine is of value in the permanent form of auricular fibrillation. The writer at present believes that there is very little to be gained by it and that the risk in its use is considerable. For general practice it should be limited to the treatment of the transient form of this arrhythmia.

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Section on Medicine—4th Tuesday in each month, Dr. Charles A. McDonald, Chairman; Dr. C. W. Skelton, Secretary and Treasurer.

R. I. Ophthalmological and Otological Society—2d Thursday—October, December, February, April and Annual at call of President Dr. Jeffrey J. Walsh, President; Dr. Francis P. Sargent Secretary-Treasurer.

The R. I. Medico-Legal Society—Last Thursday—January, April, June and October. Frederick Rueckert, Esq., President; Dr. Jacob S. Kelley, Secretary-Treasurer.

EDITORIALS

A COMMISSIONER OF HEALTH

At the time of going to press no action of the Legislature had definitely disposed of the act now before it relating to the appointment of a Commissioner of Health.

This act proposes an important change in public health government in Rhode Island at a time when need of a change was never more evident; it furthermore has the stamp of approval of the organized medical bodies of the State.

The act should pass with no opposition; it would be hard to understand adverse criticism of legislation the enacting of which speaks for the betterment of the welfare of a community.

Analytical scrutiny of its various sections impresses not only the medical men but the lay mind as well of its entire practicability.

Men with trained minds in matters of health and in disease-control have long realized an impotence in striving with problems that bear so in-

timately upon the public weal, the guardianship of which has rested with a state organization that unfortunately has never been vested with plenary powers to enforce its rulings, whose suggestions have often been ignored or repudiated and whose evident status is to all intent only that of an advisory body.

To perpetuate existing conditions that open the door, one may say, invites infringement of prescribed health laws, would appear futile and we should no longer tolerate a continuance of affairs so essentially repugnant not only to all humanitarian ideals, but what is infinitely more, to the public health welfare.

The imperative necessity of a change is obvious.

Undoubtedly, the solution of the problem is before us.

THE MEDICAL VIEW POINT

Someone has said that the very rich and the very poor get the best medical treatment, which, in the large urban communities is probably true. The rich because they are able to pay the large fees of a group of specialists, at a fashionable afternoon appointment, and the poor because they can endure the interminably long waiting period on a wooden bench, where in the forenoon they meet the same doctors at a free clinic. What has brought this about?

One does not have to look back very far to see the general physician whose position among his people was certainly as secure as that of any man. His two-wheeled chaise was hung on thorough braces, his pill case was small and invariably black as were his clothes, he had—or always assumed—an air of dignity, in fact he could make an excellent post mortem examination with no greater preparation than to turn up his coat sleeves. Was it Stevenson who said of him? "He is the flower, such as it is, of our civilization."

The outcome of a case might be determined by whether the hickory bark, from which the tea was steeped, had been gathered by stripping it up the tree for an emetic, or down the tree for a purge. When the ending was fatal, the doctor was the calm and sympathetic adviser of the family, and not infrequently sang at the funeral or at any rate bore one corner of the coffin in its difficult journey through the narrow front hall. He was a scientist in a small way, a philosopher in a large way and often achieved no small success as a poet. Peace to his ashes, for he was a hard-worked man and well deserves his long rest. He was an individualist. His descendant, the present day physician, is too well known to need any descriptive comment. Still a devotee at the shrine of Minerva, he pours his libations from test tubes, keeps his fires burning with electric thermostats, and sees the goddess with eyes that penetrate a thousand times further. But still, although to a less degree, he is an individualist.

Granted, that in time he will be what society at large wants him to be, how much at present is he doing to help cure the ills of society at large? Granted again that his goddess is most exacting upon the time of one who searches for more wisdom, is it not true that man generally finds time to accomplish that which he really desires?

His brothers in finance, industry, and agriculture, band together and go up on distant hills, where, with the obstruction of the trees removed, they are able to view the woods as an entity. To some extent, the medical profession is beginning to get such a viewpoint, but it should do it from a much wider angle than that described by the local medical society. What about the medical care of the great majority who are not very rich or very poor? What about the rural parts where doctors no longer thrive? What about health insurance? If, as students, doctors worship the goddess of wisdom, surely then, being skilled in thinking, society would welcome comments upon health problems, from them as collectivists.

AS TO PUBLIC HEALTH

What George Bernard Shaw has to say on any subject may interest but does not convince thinking readers. Criticism is a favorite pastime with many writers, but with him it is largely a commercial asset.

Just now he is heaping coals of fire upon the heads of the medical profession. He calls the doctors' "trust" or "union" the greatest ever and destined to destroy personal liberty in the treatment of the sick. It seemed that regular physicians failed to cure his wife of an ailment. Giving up

in despair he took her to a healer who promised a cure and succeeded, according to Mr. Shaw.

There is always some, and sometimes much, truth in the caustic words which flow from his pen, otherwise he could not sell his ideas for such fabulous sums.

The criticism is not new, yet it is important to realize that there are many people who support it whether their belief is honest or commercial.

There have been healers of all sorts for centuries and there always will be, so long as people want to be hoodwinked. It is their privilege to do as they please, so long as they do not endanger the lives and happiness of the public. Education is not having much effect upon the gullibility of the human race or so it seems, when one reads of the warm reception Indian sun worshippers and all sorts of isms are given in "high" society.

Physicians should not make the mistake of conducting an inquisition upon these fakers. These can't be suppressed altogether and persecution would only help their cause. If, however, a chiropractic or any other healer fails to recognize a ruptured appendix or case of diphtheria and death results no mercy should be shown.

Physicians should, however, guard the public against any official recognition of any body of untrained healers. It is a disagreeable task to go before the legislature every year yet it is the duty of every physician to do it. The very best solution of this problem is to require a uniform educational standard for all those who wish to treat sick people. A committee of the Rhode Island Medical Society is endeavoring to formulate a definite outline of educational requirements which can be incorporated into a bill and presented to the legislature. This effort should enlist the active assistance of every physician in the state.

Undoubtedly the very best method of counteracting the flamboyant promises of healers is education. Educators have developed a fine program of study which young people need to prepare them for life, but in it there is little attention given to the instruction of pupils about health and disease. The subject has always been neglected, and what has been taught is unimportant. As a result adults may know a lot about literature, science, etc., and yet be as ignorant as a child about sickness and its prevention.

Much health educating is being done but much more should be done by newspapers, magazines, lectures, etc. People are eager to learn but they want the truth and physicians should see to it that they get it, and not a lot of trash.

CLINICAL CONFERENCES

The course of Clinical Conferences are now about half completed and records of attendance have been kept. On the whole, interest in the conferences have been gratifying to those who arranged the courses. The profession has evidenced its appreciation by a surprisingly large attendance. Certain lectures have been better attended than others and indicate the subjects that are most desired. This year's program was arranged without any such knowledge available. It was even a matter of conjecture whether or not the conferences would be accepted. It now seems as if the committee would be justified in repeating them next year. In addition they will be in a position to select and enlarge those subjects which have been most enthusiastically received by reducing those in which there has been the least interest. The work this year may well be regarded as a success and with the experience already gained, next year's conferences ought to be much more valuable.

RECENT AND PENDING MILK LEGISLATION

by

FREDERIC P. GORHAM

Professor of Bacteriology, Brown University

It has been demonstrated again and again that milk not infrequently is a vehicle for carrying infection. Perhaps the dangers from this source have at times been exaggerated, and perhaps milk infection when compared with other modes of infection may be of minor importance, nevertheless we are in duty bound to encourage any movement which will lead to the decrease or elimination of milk-borne disease.

Milk-borne diseases may be divided into two groups, first those that have their origin in the

cow, and second those that come from human contamination of the milk.

Of the diseases that come from the cow tuberculosis is by far the most important. It has been amply demonstrated that a very considerable proportion of our dairy cattle are suffering from this disease. This condition is not peculiar to Rhode Island but exists the country over. It has also been demonstrated that the milk from tubercular cows may contain the living, virulent germs of tuberculosis. It is true that it is the bovine type of the disease that affects the cows, but it is also true that a large proportion of the cases of tuberculosis in children, cases of gland, bone, joint, intestinal tuberculosis, and tubercular meningitis, are also due to germs of the bovine type. The conclusion is obvious that these children contract the disease through the milk from tubercular cows.

The United States Department of Agriculture, looking at this problem not so much from the public health point of view, as from the standpoint of the elimination of economic losses caused by the disease to the farmers engaged in raising cattle and marketing dairy products, some years ago inaugurated the Tuberculosis-free Accredited Herd plan of freeing herds, areas, counties, and states from this disease. This nation-wide drive has progressed with remarkable rapidity. Over ten million cattle are now under supervision by the federal authorities. This plan involves the co-operation of the several states and the federal government, each bearing a certain share of the losses sustained by those who submit their herds to supervision. Connecticut last year appropriated $200,000, New Hampshire will spend $300,000 this year and next, Vermont will spend $200,000 this year and next, New York and Pennsylvania are spending millions for the purpose of eliminating tuberculosis from their cattle by this plan. The amounts spent by the states will be supplemented by federal funds. The federal government appropriated $3,500,000 last year for this purpose.

In Rhode Island in 1922 there were fourteen tuberculosis-free herds under federal and state supervision, and two of these were supplying milk to the Providence market. In 1924 there were 59 herds under supervision and seven were supplying milk to Providence. At the present time there are 132 herds in Rhode Island and 58 of them are supplying milk to Providence. In addition there are 14 herds in Massachusetts under supervision which supply milk to Providence. This makes a total of 72 herds free from tuberculosis supplying milk to Providence.

This very large increase in the last few months was due to the passage of a rule by the Board of Aldermen of Providence that after January 1, 1926, all raw milk sold in Providence must come from tuberculosis-free herds which are under federal and state supervision.

The second group of milk-borne diseases are those that are caused by human contamination of the milk. Epidemics of typhoid fever, scarlet fever, septic sore throat, and diphtheria have frequently been traced to infected milk. Milk handlers who carry the germs of these diseases on their hands, or in their noses and throats, are the cause of the infection of the milk. No amount of federal or state supervision of the cattle, nor medical inspection of the milk handlers will suffice always to protect against such infection. The only real safeguard is proper pasteurization of the milk. It has been definitely proven that pasteurization when properly done will surely destroy the germs of tuberculosis as well as the germs of diseases of human origin. It is true the milk may be infected after pasteurization, but at any rate pasteurization will remove the greater part of the danger from this source, and when pasteurization in the final container is perfected, it will eliminate all of it. At the same time pasteurization will not alter the appearance, taste, or food value of the milk when properly done. Certain of the vitamins may be destroyed by pasteurization, but they are easily supplied in the diet of babies and children by orange or other fruit or vegetable juices.

Because of the recognized value of pasteurization in the elimination of human infection of the milk, as well as the dangers from tubercular cows, the Board of Aldermen of the City of Providence ruled that after January 1, 1926, all milk other than milk from herds under federal and state supervision shall be properly pasteurized. The City of Newport has required for some years that all milk sold in Newport shall be certified milk or shall be properly pasteurized.

There is a growing tendency on the part of health authorities to require that all milk be

pasteurized. Tuberculosis-free herds protect against tuberculosis but not against human infection. Pasteurized milk protects against both. Last year nearly 70 per cent. of the milk sold in Providence was pasteurized. This year the proportion will be nearer 90 per cent. It is above 90 per cent. in most large cities.

The protection of the health of the people of the entire state is just as important as the protection of the health of the people of Providence and Newport. We therefore urge that the present General Assembly make a sufficient appropriation to reimburse those dairymen who have during the past year, without state or federal aid, because of the small state appropriation available, submitted their herds to federal supervision, and also sufficient to finance a comprehensive plan looking toward the ultimate elimination of all tubercular cattle from the entire state.

And also we urge the passage of some one of the bills now before the legislature, or some similar bill, which will require that all milk be graded and labelled, and that all raw milk shall come from herds of cows under federal and state supervision, and that all other milk shall be pasteurized. Proper labelling of the different grades of milk is necessary for the protection of the consumer, and also to prevent the use of special labels indicating a superior quality of the milk, when perhaps the superior quality is only in the label or the price. Such laws will be in the interest of both the producer and the consumer of milk.

SOCIETIES

Providence Medical Association

The regular monthly meeting of the Providence Medical Association was called to order by the President, Dr. Albert H. Miller, Monday evening, December 7, 1925, at 8:50 o'clock.

The records of the last meeting were read and approved.

An invitation to attend the next meeting of the R. I. Ophthalmological and Otological Society was read.

Dr. George Mathews read the report of the committee on the duties and personnel of a medical milk commission.

Personnel of the Medical Milk Commission will be Dr. W. P. Buffum, Jr., as chairman, Drs. W. H. Jordan, Morris Adelman, R. C. Bates and A. R. Newsam. Duties will be to receive petitions to produce a certified milk, to designate a sanitary inspector, a veterinary for cows, a physician to examine the employees of the farm and an analyist to make bacterial counts and contents of elements of milk.

This was approved and ordered placed on file.

The Standing Committee having approved the applications for membership of the following the Secretary was instructed to cast one ballot for their election: Elizabeth L. Martin, Florian G. Ruest, Paul F. Thompson, Benjamin S. Sharpe.

In accordance with Article 1, Section 6, of the By-Laws, the Standing Committee presented the following nominations for officers and committees for the year 1926.

For President—Roland Hammond, M.D.

For Vice-President—Henry J. Hoye, M.D.

For Secretary—Peter Pineo Chase, M.D.

For Treasurer—Charles F. Deacon, M.D.

For Members of the Standing Committee for five years—Albert H. Miller, M.D.

For Trustee of the Rhode Island Medical Library for one year—Dennett L. Richardson, M.D.

For Reading Room Committee — George S. Mathews, M.D., Elihu Wing, M.D., Herman C. Pitts, M.D.

For Delegates to the House of Delegates of the Rhode Island Medical Society—H. G. Partridge, M.D., A. H. Ruggles, M.D., A. M. Burgess, M.D., F. V. Hussey, M.D., W. F. Flanagan, M.D., M. B. Milan, M.D., H. B. Sanborn, M.D., L. C. Kingman, M.D., E. S. Cameron, M.D., W. H. Higgins, M.D., A. J. McLoughlin, M.D., P. P. Chase, M.D., F. E. McEvoy, M.D., A. Corvese, M.D., M. Adelman, M.D., P. C. Cook, M.D., C. W. Skelton, M.D.,

Dr. Elihu S. Wing read the first paper of the evening, on pneumonia with special reference to treatment. The incidence of this disease does not diminish and the death rate has changed little in spite of scientific work. After a short talk on the four groups of pneumococci he showed curves of temp. white count and blood cultures and discussed its treatment.

His conclusions were: The laboratory should be used. The patient receive supportive treatment, rest and quiet, plenty of fluids, attention to bowels and chronic alcoholics should get alcohol. Stimulants should be limited. Digitalis should be given early and venesection when indicated. Diathermy seems of value in relieving symptoms at least. Serum is of value only in type one.

The paper was discussed by Drs. Wells, Mowry, Mathews, De Wolf, White and Wing.

Prof. Philip H. Mitchell of Brown University read a paper on "Some New Researches on Blood Sugar." The report dealt with newer researches on the nature of blood sugar, especially with work that has led to the theory that insulin reaching in the body with a substance that has been found in muscle changes glucose into some hitherto unrecognized form.

Dr. Skelton read a poem. The meeting adjourned at 10:45 A. M. Attendance 69. Collation was served.

Respectfully submitted

Peter Pineo Chase
Secretary

The annual meeting of the Providence Medical Association was called to order by the President, Dr. Albert H. Miller, Monday evening, January 4, 1926, at 8:48 o'clock.

The records of the last meeting were read and approved.

The reports of the Secretary, Treasurer, Standing Committee and Reading Room Committee were read, accepted and ordered placed on file.

The President's annual address by Dr. Miller was on "Ideals and Ethics."

At this, the 76th annual meeting, the Association is found to be successful and carrying out the objects for which it was formed. The "advancement of sound medical science" was handicapped only by our lack of time. As the local representative of the American Medical Association, the ethics were kept on a high plane, evidenced by the great medical reforms this latter had achieved throughout the country.

He warned against the submergence of the general practitioner by the specialist and showed how the school of homeopathy had gradually lost its identity and merged into the generally accepted field of scientific medicine. In conclusion he spoke kind words for his associates in the conduct of the Association.

The Secretary was instructed to cast one ballot for the entire list of officers.

Dr. Hammond was escorted to the chair by Drs. Cutts and Van Benschoten. After a few remarks he appointed the following committees:

Collation—Wilfred Pickles, Ralph DiLeone.

Publicity—Charles A. McDonald, Joseph F. Hawkins, Robert C. Robinson.

A letter from Mrs. Swarts was read in appreciation of the memorial on Dr. Swarts. Also an invitation from the St. Camillus Guild for Catholic Nurses to a lecture on Psycho-Analysis by Dr. James J. Walsh.

It was voted to give $175.00 to the R. I. Medical Society Library for the purchase of Journals and $250.00 for binding Journals. Also $450.00 to the Society for the use of the building. It was voted to make the dues $5.00 for the ensuing year.

Dr. Reuben C. Bates read a paper on Observations of the Health of Children in an Institution. This was a survey of the children in St. Mary's Orphanage with their routine of life and showed an apparent relationship between undernourishment and signs of tuberculosis.

Dr. Buffum opened the discussion and was followed by Drs. W. H. Jordan, Pinckney and Kelley.

Dr. Frederick N. Brown paid a tribute to the retiring President.

Dr. White read a poem. Meeting adjourned at 10:15 P. M. Attendance 54. Collation was served.

Respectfully submitted

PETER PINEO CHASE
Secretary

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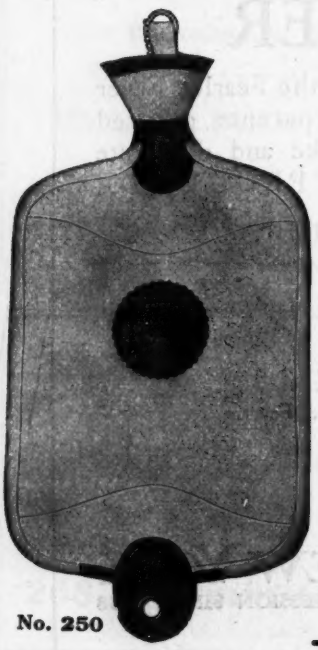

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